



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care



NATIONAL
GUIDELINE
CLEARINGHOUSE

General

Guideline Title

Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement.

Bibliographic Source(s)

U.S. Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2013 Mar 19;158(6):478-86. [48 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

This release updates a previously published guideline: Screening for family and intimate partner violence: recommendation statement. *Ann Intern Med* 2004 Mar 2;140(5):382-6. [46 references]

Recommendations

Major Recommendations

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the levels of certainty regarding net benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation). This recommendation applies to women who do not have signs or symptoms of abuse. See the Clinical Considerations below for more information on effective interventions.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement). See the Clinical Considerations below for suggestions for practice regarding the I statement.

Clinical Considerations

Patient Population under Consideration

These recommendations apply to asymptomatic women of reproductive age and elderly and vulnerable adults. Reproductive age is defined across studies as ranging from 14 to 46 years, with most research focusing on women age 18 years or older. The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or

same-sex couples and does not require sexual intimacy. A vulnerable adult is a person age 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired because of a mental, emotional, long-term physical, or developmental disability or dysfunction or brain damage. Definitions vary by state and sometimes include the receipt of personal care services from others. Types of abuse that apply to elderly and vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect.

Child abuse and neglect is addressed in a separate recommendation.

Assessment of Risk

Although all women are at potential risk for abuse, factors that elevate risk include young age, substance abuse, marital difficulties, and economic hardships.

Screening Tests

Several screening instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS; English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST).

The HITS instrument includes 4 questions, can be used in a primary care setting, and is available in both English and Spanish. It can be self- or clinician-administered. HARK is a self-administered 4-item instrument. STaT is a 3-item self-report instrument that was tested in an emergency department setting.

The USPSTF found no valid, reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting.

Screening Interval

The USPSTF found no evidence on appropriate intervals for screening.

Interventions

Evidence from randomized trials support various interventions for women of childbearing age, including counseling, home visits, information cards, referrals to community services, and mentoring support. Depending on the type of intervention, these services may be provided by clinicians, nurses, social workers, nonclinician mentors, or community workers. Counseling generally includes information on safety behaviors and community resources. In addition to counseling, home visits may include emotional support, education on problem-solving strategies, and parenting support. One study used a 20-minute nurse case management protocol focusing on a safety plan, supportive care, and guided referrals. No intervention studies were identified for elderly or vulnerable adults. See the following discussion for suggestions for practice in this population.

Suggestions for Practice Regarding the I Statement for Elderly or Vulnerable Adults

Potential Benefits

The estimated prevalence of elder abuse ranges from 2% to 10% according to various definitions, methods, and sampling strategies. One study indicated that 1 in 10 elderly adults may experience abuse, but only 1 in 5 or fewer cases are actually reported.

Potential Harms

Although there is no direct evidence, the existing evidence about the lack of harms resulting from IPV screening suggests that the harms of screening elderly and vulnerable adults might also be small. Some potential harms of screening include shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and the repercussions of false-positive results.

Costs

There is no evidence about the costs of screening for or interventions to reduce elder abuse.

Current Practice

Screening practices for elder abuse are limited for many reasons. Currently, there are no standards about how clinicians should ask elderly patients about possible abuse. In addition, there are varying definitions of abuse, a wide variety of mechanisms of elder abuse, no universal screening tools, wide-ranging risk factors, unclear guidance about whom to screen and what to do if abuse is identified, physician discomfort with screening, and time constraints. Screening is not done routinely and varies by locality. However, all providers should be aware of the laws in their states for

reporting suspected abuse. Not all states mandate reporting, and some provide clear guidance about what type of injuries should arouse suspicion.

Useful Resources

The USPSTF has several recommendations that may be relevant, including screening for depression (see USPSTF guideline Screening for Depression in Adults: U.S. Preventive Services Task Force Recommendation Statement) and alcohol misuse (Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse; update in progress).

Other useful resources include Web sites that contain materials useful to primary care providers. Providers often need guidance on how to address concerns about IPV with sensitivity and clarity and how to screen for IPV and provide follow-up care. Intimate partner violence introduces significant safety issues that compel a provider to be fully informed on such aspects as sensitivity. Providers also need easy access to available tools, specific guidelines, and other related materials to help them develop a clinical environment dedicated to the safety of their patients. Guidance is also available on how providers can work with local community-based domestic violence programs to receive training, information, and other resources to ensure effective management of patients who are victims of IPV.

Providers should also be aware of their state and local reporting requirements. The laws vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom. Although reporting suspected elder and child abuse is mandated in all 50 states and the District of Columbia, this is not the case with IPV. In addition, providers also need to be familiar with requirements in the privacy regulations of the federal Health Insurance Portability and Accountability Act, which require that patients be advised on health information use and disclosure practices. Again, state laws around privacy issues or concerns vary.

The Centers for Disease Control and Prevention (CDC) has resources available for those needing additional information at www.cdc.gov/ViolencePrevention/intimatepartnerviolence/resources.html .

Definitions:

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

| Grade | Grade Definitions | Suggestions for Practice |
|----------------|--|---|
| A | The USPSTF recommends the service. There is high certainty that the net benefit is substantial. | Offer/provide this service. |
| B | The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. | Offer/provide this service. |
| C | The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. | Offer/provide this service only if other considerations support offering or providing the service in an individual patient. |
| D | The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. | Discourage the use of this service. |
| I Statement | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. | Read the "Clinical Considerations" section of USPSTF Recommendation Statement (see the "Major Recommendations" field). If the service is offered, patients should understand the uncertainty about the balance of benefits and harms. |

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.

| Level of Certainty | Description |
|--------------------|---|
| High | The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary |

| Level of Certainty | Description |
|--------------------|---|
| Moderate | <p>care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</p> <p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none"> • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice; and • Lack of coherence in the chain of evidence <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p> |
| Low | <p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings that are not generalizable to routine primary care practice; and • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p> |

Clinical Algorithm(s)

None available

Scope

Disease/Condition(s)

- Intimate partner violence (IPV)
- Abuse and neglect of elderly and vulnerable adults

Guideline Category

Prevention

Screening

Clinical Specialty

Emergency Medicine

Family Practice

Geriatrics

Internal Medicine

Obstetrics and Gynecology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Emergency Medical Technicians/Paramedics

Hospitals

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

To update the 2004 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for family and intimate partner violence (IPV)

Target Population

- Asymptomatic women (women who do not have signs or symptoms of abuse) of reproductive age
- Elderly and vulnerable adults

Interventions and Practices Considered

1. Screening women of childbearing age for intimate partner violence (IPV), such as domestic violence
2. Providing or referring women who screen positive to intervention services
3. Screening elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (insufficient evidence to make a recommendation)

Major Outcomes Considered

Key Questions for Intimate Partner Violence (IPV)

Key Question 1: Does screening asymptomatic women in health care settings for current, past, or increased risk for IPV reduce exposure to IPV, physical or mental harms, or mortality?

Key Question 2: How effective are screening techniques in identifying asymptomatic women with current, past, or increased risk for IPV?

Key Question 3: What are the adverse effects of screening for IPV?

Key Question 4: For screen-detected women with current, past, or increased risk for IPV, how well do interventions reduce exposure to IPV, physical or mental harms, or mortality?

Key Question 5: What are the adverse effects of interventions to reduce harm from IPV?

Key Questions for Elder and Vulnerable Adult Abuse and Neglect

Key Question 1: Does screening asymptomatic elderly and vulnerable adults in health care settings for current, past, or increased risk for abuse and neglect reduce exposure to abuse and neglect, physical or mental harms, or mortality?

Key Question 2: How effective are screening techniques in identifying asymptomatic elderly and vulnerable adults with current, past, or increased risk for abuse and neglect?

Key Question 3: What are the adverse effects of screening for abuse and neglect of elderly and vulnerable adults?

Key Question 4: For screen-detected elderly and vulnerable adults with current, past, or increased risk for abuse and neglect, how well do interventions reduce exposure to abuse and neglect, physical or mental harms, or mortality?

Key Question 5: What are the adverse effects of interventions to reduce harm from abuse and neglect?

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC), Oregon Health & Science University for the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Search Strategies

Reviewers searched the Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews through the fourth quarter of 2011, and MEDLINE and PsycINFO from 2002 to January 9, 2012, for relevant studies and systematic reviews. Search strategies and additional details are described in Appendix B1 of the evidence synthesis. Reference lists of papers and citations of key studies were also reviewed manually and by using Scopus. Studies published in 2003 or later were eligible for inclusion in this update.

Study Selection

Studies were selected on the basis of inclusion and exclusion criteria developed for each Key Question see (Appendix B2 of the evidence synthesis). Appendix B3 of the evidence synthesis shows the results of the literature search and selection process. For all studies, reviewers included research conducted in the United States or in other populations similar to the screening populations targeted in this review that received services and interventions applicable to U.S. medical practice.

For Key Questions 1 and 4, reviewers included randomized, controlled trials (RCTs) of the effectiveness of screening (Key Question 1) or interventions (Key Question 4) for intimate partner violence (IPV) or elder abuse in reducing exposure to abuse and health outcomes as defined by the Key Questions. Studies of screening or referral rates, attitudes about screening, plans or intentions, or reporting other types of intermediate outcomes were not included.

For Key Question 2, reviewers included studies of the diagnostic accuracy of screening techniques in identifying asymptomatic women and elderly/vulnerable adults in health care settings with current or past violence and abuse or at high risk for violence and abuse. Screening tests were included if they were used in or were applicable to U.S. primary care settings. These included self-administered, computer-enabled, or patient self-report instruments, as well as clinician-to-patient methods. Instruments were included if they were feasible for use for screening (i.e., brief, easy to interpret, acceptable to patients and clinicians). Studies of diagnostic accuracy reporting sensitivity, specificity, area under the curve, or other characteristics (Table 3 of the evidence synthesis) were included. Reviewers excluded studies lacking a validated reference standard, examining instruments that are not feasible for screening in health care settings, or evaluating instruments in populations different than the target populations for this review. Studies of externally validated techniques, particularly if utilizing large and/or multiple samples, were preferred over studies of internally validated or nonvalidated techniques.

For Key Questions 3 and 5, reviewers included studies on adverse effects of screening and interventions. Consistent with other reviews, inclusion criteria were broadened to include studies of multiple designs to describe potential adverse effects. Studies included for Key Questions 1 and 4 were reviewed for outcomes relevant to Key Questions 3 and 5.

Existing relevant systematic reviews were obtained and included if the individual studies within the review meet inclusion criteria; otherwise, the relevant individual studies were included. Studies examining patient or physician education and methods of increasing screening or disclosure rates were excluded. Reviewers also excluded studies about the use of services or referral for services if they did not also include health outcomes, and the perceptions and attitudes of physicians and nurses on screening for IPV or elder abuse. Excluded studies are listed in Appendix B4 of the evidence synthesis.

Number of Source Documents

Intimate Partner Violence

Key question 1 (screening effectiveness): 1 randomized controlled trial

Key question 2 (screening techniques): 15 studies

Key question 4 (interventions): 6 randomized controlled trials (in 8 articles)

Key questions 3 and 5 (adverse effects): 14 studies

Abuse and Neglect of Elderly and Vulnerable Adults

Key question 1 (screening effectiveness): No randomized controlled trials or controlled observational studies

Key Question 2 (diagnostic accuracy): 1 study

Key Question 4 (interventions): No randomized controlled trials or controlled observational studies; 1 descriptive retrospective study

Key Questions 3 and 5 (adverse effects): No studies

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Two investigators rated the quality of studies (good, fair, poor) and resolved discrepancies by consensus (described in Appendixes B5 and B6 of the evidence synthesis; see the "Availability of Companion Documents" field).

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC), Oregon Health & Science University for the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Abstraction and Quality Rating

Reviewers abstracted details about the patient population, study design, analysis, follow-up, and results. USPSTF quality criteria were used to determine the quality of individual studies. Two investigators rated the quality of studies (good, fair, poor) and resolved discrepancies by consensus (described in Appendixes B5 and B6 of the evidence synthesis). Studies with designs that lack quality criteria were qualitatively described.

Data Synthesis

Reviewers assessed the aggregate internal validity (quality) of the body of evidence for each Key Question (good, fair, poor) using methods developed by the USPSTF based on the number, quality, and size of studies, consistency of results between studies, and directness of evidence. No quantitative analysis, such as meta-analysis, was conducted.

Methods Used to Formulate the Recommendations

- Balance Sheets
- Expert Consensus

Description of Methods Used to Formulate the Recommendations

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

| Certainty of Net Benefit | Magnitude of Net Benefit | | | |
|--------------------------|--------------------------|----------|-------|---------------|
| | Substantial | Moderate | Small | Zero/Negative |
| High | A | B | C | D |
| Moderate | B | B | C | D |
| Low | Insufficient | | | |

*A, B, C, D, and I (*Insufficient*) represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist the USPSTF in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an

overall assessment of the evidence about net benefit. To avoid confusion, the Task Force has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that one of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med.* 2007;147:871-875. [5 references]

I Statements

For I statements, the USPSTF has a new plan to commission its Evidence-based Practice Centers to collect information in 4 domains pertinent to clinical decisions about prevention and to report this information routinely. This plan is described in the paper: Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. *Ann Intern Med.* 2009;150:199-205. www.annals.org

The first domain is potential preventable burden of suffering from the condition. When evidence is insufficient, provision of an intervention designed to prevent a serious condition (such as dementia) might be viewed more favorably than provision of a service designed to prevent a condition that does not cause as much suffering (such as rash). The USPSTF recognized that "burden of suffering" is subjective and involves judgment. In clinical settings, it should be informed by patient values and concerns.

The second domain is potential harm of the intervention. When evidence is insufficient, an intervention with a large potential for harm (such as major surgery) might be viewed less favorably than an intervention with a small potential for harm (such as advice to watch less television). The USPSTF again acknowledges the subjective nature and the difficulty of assessing potential harms: for example, how bad is a "mild" stroke?

The third domain is cost—not just monetary cost, but opportunity cost, in particular the amount of time a provider spends to provide the service, the amount of time the patient spends to partake of it, and the benefits that might derive from alternative uses of the time or money for patients, clinicians, or systems. Consideration of clinician time is especially important for preventive services with only insufficient evidence because providing them could "crowd out" provision of preventive services with proven value, services for conditions that require immediate action, or services more desired by the patient. For example, a decision to routinely inspect the skin could take up the time available to discuss smoking cessation, or to address an acute problem or a minor injury that the patient considers important.

The fourth domain is current practice. This domain was chosen because it is important to clinicians for at least 2 reasons. Clinicians justifiably fear that not doing something that is done on a widespread basis in the community may lead to litigation. More important, addressing patient expectations is a crucial part of the clinician–patient relationship in terms of building trust and developing a collaborative therapeutic relationship. The consequences of not providing a service that is neither widely available nor widely used are less serious than not providing a service accepted by the medical profession and thus expected by patients. Furthermore, ingrained care practices are difficult to change, and efforts should

preferentially be directed to changing those practices for which the evidence to support change is compelling.

Although the reviewers did not explicitly recognize it when these domains were chosen, the domains all involve consideration of the potential consequences—for patients, clinicians, and systems—of providing or not providing a service. Others writing about medical decision making in the face of uncertainty have suggested that the consequences of action or inaction should play a prominent role in decisions.

Rating Scheme for the Strength of the Recommendations

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

| Grade | Grade Definitions | Suggestions for Practice |
|----------------|--|---|
| A | The USPSTF recommends the service. There is high certainty that the net benefit is substantial. | Offer/provide this service. |
| B | The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. | Offer/provide this service. |
| C | The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. | Offer/provide this service only if other considerations support offering or providing the service in an individual patient. |
| D | The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. | Discourage the use of this service. |
| I Statement | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. | Read the "Clinical Considerations" section of USPSTF Recommendation Statement (see the "Major Recommendations" field). If the service is offered, patients should understand the uncertainty about the balance of benefits and harms. |

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.

| Level of Certainty | Description |
|--------------------|--|
| High | The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies. |
| Moderate | <p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none">• The number, size, or quality of individual studies• Inconsistency of findings across individual studies• Limited generalizability of findings to routine primary care practice; and• Lack of coherence in the chain of evidence <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p> |
| Low | <p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none">• The limited number or size of studies• Important flaws in study design or methods• Inconsistency of findings across individual studies• Gaps in the chain of evidence |

| Level of Certainty | Description |
|--------------------|---|
| | <ul style="list-style-type: none"> Findings that are not generalizable to routine primary care practice; and A lack of information on important health outcomes |
| | More information may allow an estimation of effects on health outcomes. |

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to Federal agencies and professional and disease-based health organizations with interests in the topic. The experts are asked to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the USPSTF in memo form. In this way, the USPSTF can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment among reviewers representing professional societies, voluntary organizations, and Federal agencies, as well as posted on the Task Force Web site for public comment. These comments are discussed before the final recommendations are confirmed.

Response to Public Comment. A draft version of the recommendation statement was posted for public comment on the USPSTF Web site from 12 June through 10 July 2012. Some comments expressed concerns about the lack of a focus on violence against men and other missed populations in the scope of this review. Additional comments highlighted the existence of new evidence that had been published since the initial review. Several comments requested information for additional resources or tools to assist providers in responding to patients experiencing intimate partner violence. Finally, some comments focused on the exclusion of women age 46 years and older in the recommendation. In response to these comments, the USPSTF acknowledged the prevalence of abuse against men and agreed that in addition to women older than age 46 years and the elderly, there are many understudied issues. The USPSTF also included specific information in the statement to help providers find additional resources and tools.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: the American Congress of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family Physicians, the American College of Emergency Physicians, the American Academy of Pediatrics, the Emergency Nurses Association, and the American Academy of Neurology.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated for each recommendation.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Benefits of Detection and Early Intervention

- The U.S. Preventive Services Task Force (USPSTF) found adequate evidence that effective interventions can reduce violence, abuse, and physical or mental harms for women of reproductive age.
- The USPSTF found inadequate evidence that screening or early detection reduces exposure to abuse or reduces physical or mental harms or mortality for elderly and vulnerable adults.

Potential Harms

Harms of Detection and Early Intervention

- For intimate partner violence, the U.S. Preventive Services Task Force (USPSTF) found adequate evidence that the risk for harm to the individual from screening or interventions is no greater than small.
- For elderly and vulnerable adults, the USPSTF found inadequate evidence on the harms of screening or interventions.

Suggestions for Practice Regarding the I Statement for Elderly or Vulnerable Adults

Although there is no direct evidence, the existing evidence about the lack of harms resulting from IPV screening suggests that the harms of screening elderly and vulnerable adults might also be small. Some potential harms of screening include shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and the repercussions of false-positive results.

Qualifying Statements

Qualifying Statements

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without related signs or symptoms.
- It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.
- The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.
- Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Implementation of the Guideline

Description of Implementation Strategy

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the USPSTF Task Force will make all its products available through its [Web site](#) . The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size Guide to Clinical Preventive Services.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

Implementation Tools

Foreign Language Translations

Mobile Device Resources

Patient Resources

Pocket Guide/Reference Cards

Resources

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

U.S. Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2013 Mar 19;158(6):478-86. [48 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1996 (revised 2013 Mar 19)

Guideline Developer(s)

U.S. Preventive Services Task Force - Independent Expert Panel

Guideline Developer Comment

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

Source(s) of Funding

United States Government

Guideline Committee

U.S. Preventive Services Task Force (USPSTF)

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**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to <http://www.uspreventiveservicestaskforce.org/Page/Name/our-members> .*

Financial Disclosures/Conflicts of Interest

The U.S. Preventive Services Task Force (USPSTF) has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. USPSTF members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

Disclosure forms from USPSTF members can be viewed at www.acponline.org/authors/icmjje/ConflictOfInterestForms.do?msNum=M12-3146

Guideline Status

This is the current release of the guideline.

This release updates a previously published guideline: Screening for family and intimate partner violence: recommendation statement. Ann Intern Med 2004 Mar 2;140(5):382-6. [46 references]

Guideline Availability

Electronic copies: Available from the [Annals of Internal Medicine Web site](#) .

Availability of Companion Documents

The following are available:

Evidence Review:

- Nelson HD, Bougatsos C, Blazina, I. Screening women for intimate partner violence: a systematic review to update the 2004 U.S. Preventive Services Task Force recommendation. Ann Intern Med 2013; 156:1-13.
- Nelson HD, Bougatso, B, Blazina, I. Screening women for intimate partner violence and elderly and vulnerable adults for abuse: systematic review to update the 2004 U.S. Preventive Services Task Force recommendation. Evidence synthesis no. 92. AHRQ publication no. 12-05167-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2012.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#) .

Background Articles:

- Barton MB et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med 2007;147:117-122.
- Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med 2007;147:871-875.
- Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. Ann Intern Med. 2009;150:199-205.

Electronic copies: Available from the [USPSTF Web site](#) .

The following is also available:

- Screening for intimate partner violence and abuse of elderly and vulnerable adults. Clinical summary of U.S. Preventive Services Task Force Recommendations. Rockville (MD): Agency for Healthcare Research and Quality; 2013 Jan. Available from the [USPSTF Web site](#) .
- Screening for intimate partner violence and abuse of elderly and vulnerable adults. CME course. Electronic copies: Available from the [Annals of Internal Medicine Web site](#) .
- The guide to clinical preventive services, 2012. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2012. 128 p. Electronic copies available from the [AHRQ Web site](#) . See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#) .

A Chinese translation of the recommendation only is available from the [Annals of Internal Medicine Web site](#) .

The [Electronic Preventive Services Selector \(ePSS\)](#) , available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate

for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

Patient Resources

The following are available:

- Screening for intimate partner violence and abuse of elderly and vulnerable adults. Understanding Task Force recommendations. U.S. Preventive Services Task Force. Consumer fact sheet. 2013 Jan. 4 p. Electronic copies: Available from the [U.S. Preventive Services Task Force Web site](#) .
- Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation. Summary for patients. 2013. 1 p. Electronic copies: Available from the [Annals of Internal Medicine Web site](#) .
- Women: stay healthy at any age. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 10-IP002-A. 2010 Aug. 2 p. Electronic copies: Available in Portable Document Format (PDF) in [English](#) and [Spanish](#) from the AHRQ Web site. See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#) .

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/research/publications/index.html> or call 1-800-358-9295 (U.S. only).

Myhealthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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